STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at the facility from May 11, 2011 through May 18, 2011. The deficiencies contained in this survey are based on observations, interviews, and review of residents' clinical records and other facility documentation as indicated. The census on the first day was one hundred-nine (109). The Stage II sample included 26 residents.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to provide care in a manner that promotes dining with dignity. Findings include: 1. A lunch observation was made on the secured unit (Holly) for the cognitively impaired on 5/11/11 between 11:50 AM to 12:30 PM. Staff went around putting clothing protectors around the residents' necks without asking the residents if they wanted to wear one. 2. A second lunch observation on Holly unit on 5/13/11 at 12 PM noted the same practice of staff putting clothing protectors on residents without asking if they wanted one.	F 241	**F 241** 1. Residents are now being asked if they want to wear clothing protectors. 2. Residents who need clothing protectors are at risk for this deficient practice. 3. The Staff Development Director and or designee will re-in-service the Nursing Staff and trained feeders on offering the residents clothing protectors. Random observation audits will be completed weekly for four weeks to evaluate whether residents are being offered clothing protectors 4. The results of the observation audit will be forwarded to the Quality Assurance and Assessment Committee. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.	July 26, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6/9/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 3. On 5/11/11 at 12:09, 14 residents were observed in the assisted dining room on the Scott unit. Clothing protectors were applied to all but two of the residents without asking the resident's permission or notifying the residents. 4. On 5/17/11, during the lunch meal, the above practice was observed several times again on the Scott unit assisted dining room.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide on-going activities to meet the individualized needs and interests of one (R194) out of twenty six residents sampled. Findings include: 1. The Minimum Data Set (MDS) dated 1/3/11 for R194 coded a 1 under signs and symptoms of delirium (had difficulty focusing attention and disorganized thinking). Additionally this MDS coded the resident as 02 in C500 meaning the resident was cognitively impaired. This same MDS also stated that R194 required extensive assistance for bed mobility, locomotion, dressing and toilet use.	F 248	**F 248** 1. R194 is now being offered activities of interest. 2. All residents had the potential to be effected by this deficient practice 3. Activities department will develop and initiate a resident activity attendance monitoring system to maintain a record of when a resident is attending or being encouraged to attend an activity of interest. Audits will be conducted weekly for four weeks to evaluate whether there is documentation of residents attending or being encouraged to attend activities of interest 4. The results of the audit will be forwarded to the Quality Assurance and Assessment Committee. The Quality Assurance and Assessment Committee will review and determine the need for further audits and or action plans.	July 26, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 2 R194, admitted in December 2010, was observed to be a passive observer in group activities that took place at the nurses station throughout the survey. No individualized or meaningful, activity, that engaged this cognitively impaired resident, was observed. Some of the group activities that were observed included; word games, travel book reading, chip toss, patriotic singing, Elvis Presley music, and story reading. R194 either declined or took no active part in these activities. The activities records in the chart contained an initial and a quarterly review for this resident. This wheelchair bound resident was assessed as liking swing music, interacting with children, interacting with animals, and cooking. The assessment indicated that the resident should be invited to group activities for stimulation and socialization. Interview 5/17/11 at 11:00 AM with the activities supervisor, E5, indicated there was no on-going, daily or weekly, charting of activities for R194. The resident activity was being reviewed as a quarterly summary in the chart. There was no evidence that R194 was attending or being encouraged to attend activities of interest. A cooking activity occurred on the Holly unit during the survey and R194 was not in attendance despite having cooking listed as an interest. While the facility had an activity program for cognitively impaired residents in the locked unit R194 did not attend that special program because he was not on the locked unit.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that for one (R104) out of 26 sampled residents, the comprehensive care plan included measurable objectives to meet a resident's needs. Findings include: Review of R104's initial activities assessment dated 12/3/08 noted current interests included church music, television (soap operas, food channel), and baking/cooking. R104's most recent annual activity assessment dated 9/20/10 noted R104 was currently participating in the following activities: relaxation/solace, religious	F 279	**F 279** 1. The Activity care plan for R104 was updated to include measurable objectives to meet resident needs 2. All other residents Activity care plans will be reviewed for measurable objectives and revised or updated as necessary. 3. The Activity staff will be re-in-serviced on developing care plans that include measurable objectives for all residents. A random audit will be completed to evaluate whether resident's Activity care plans include measurable objectives. 4. The results of the audit will be forwarded to the Quality Assurance and Assessment Committee. The Quality Assurance and Assessment Committee will review the audits to determine the need for further audits and or action plans.	June 9, 2011 July 26, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 activities, and one on one. Review of R104's activities care plan initiated on 10/29/09 noted she prefers not to attend group activities due to preference to pursue independent activities and prefers to stay in room most days. Goal for this care plan was that R104 will participate in independent leisure activities of choice such as watching TV and reading for the next 90 days. Interventions included: - Assist in planning encourage to plan own leisure time activities - Encourage participation in group activities of interest - Give verbal reminders of activity before commencement of activity Care plan reassessments dated 12/10/10 noted "Quarterly Care Plan (QCP) Review, continues to receive one on one visits" and 3/1/11, "QCP Review, continues to receive one on one visits and enjoys reading her morning sheets.." Although the facility developed a care plan, the facility failed to include a measurable objective to meet R104's needs. Additionally, the facility failed to individualize the interventions as noted above since R104 prefers not to attend group activities, however, one of the interventions included to encourage participation in group activities of interest. Interview with E5 (Activities Director) on 5/18/11 at approximately 8:30 AM revealed that the Activities Department does not currently track R104's activities participation (i.e. daily, weekly, monthly basis).	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R200, R194, and R104) out of 26 residents the facility failed to ensure the adequate indication for use and/or monitoring of medications. Findings include: 1. R200 had a physician's order originating 2/4/11 for Melatonin (natural sleep remedy) 3 mg.	F 329	**F 329** 1. R200, R194 and R104 will have their medical records updated to ensure there is adequate indication for use &/or monitoring of medications. R200's melatonin was discontinued on 6/7/11 2. All other residents with orders for hypnotics and blood thinners will have their records reviewed to ensure there is adequate indication for use and/or monitoring of medications 3. The Staff Developer or designee will re-in-service the Nursing Staff on writing physician orders to include adequate indication for use and/or monitoring of medications. Audits of resident records will be completed weekly x 4 to evaluate whether the adequate indication for use and/or monitoring of medications is present. 4. The results of the audit will be forwarded to the Quality Assurance and Assessment Committee for their review. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.	July 26, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 (milligram) qd (every day) for sleep and an order originating on 4/12/11 for Ambien (hypnotic) 10 mg. at hs (bedtime) for sleep. The resident's current care plan for potential sleep pattern disturbance related to difficulty sleeping as manifested by insomnia included the approach of monitoring the effectiveness of the use of the hypnotic. Review of the Behavior Monitoring Flow Sheets (BMF) for April 2011 and May 2011 revealed that insomnia was not being monitored. An interview on 5/16/11 at 12:50 PM with the unit manager (E6) revealed that there was no evidence that the use of two sleep medications was reviewed and confirmed that the insomnia was not being monitored. An interview on 5/16/11 at 1:20 PM with E2 (Director of Nursing/DON) and E6 revealed that the physician had just been contacted and wanted the resident to be on both of the sleep medications since they were working so well. It was again confirmed that insomnia had not been monitored. 2. Resident R194 was being given aspirin at 8 (sic) mg. by mouth daily. No diagnosis or rationale was listed for the use of this medication. The unit manager, E4, was interviewed regarding the use of the aspirin and referred to the RNAC, E9, who indicated the aspirin was on R194's regimen upon admission and was being used prophylactically related to falls. The monthly pharmacy reviews did not address the use of	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 aspirin for this resident. 3. Review of R102's May 2011 Physician's Order Sheet noted that R102 was on Plavix (medication used to prevent strokes and heart attacks in patients at risk for these problems)75 mg. daily blood thinner. Record review lacked adequate indication for use of this medication. Subsequent to the surveyor's inquiry on 5/13/11, record review revealed a new order dated 5/16/11 which noted diagnosis for the use of Plavix as history of cerebral vascular accident (stroke).	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 8 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	F 334 1. R7 will be reoffered the pneumococcal vaccination and education related to potential side effects will be given to the Resident's legal representative. 2. All other residents had the potential to be affected by this deficient 3. The Facility policy will be reviewed and revised as necessary to include an educational component to ensure that the resident or legal representative receive information related to the benefits and potential side effects of receiving the pneumococcal immunization. The Staff Developer or designee will in-service the Nursing Staff on the revised policy. Audits will be completed to evaluate whether residents are reoffered the pneumococcal vaccination if they have refused. 4. The results of the audit will be forwarded to the Quality Assessment and Assurance Committee. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.	July 26, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 9	F 334		

This REQUIREMENT is not met as evidenced by:
Based on record review, review of facility policies, and staff interview, it was determined that the facility's influenza immunization and pneumococcal vaccination policies failed to have the educational component and failed to ensure that the residents or legal representatives were educated with the benefits and potential side effects of receiving the immunization. In addition, the facility failed to re-offer the pneumococcal vaccination to one (R7) out of five sampled residents. Findings include:

1. Review of facility's policy titled "Influenza Immunization Program" documented that residents will be offered vaccination annually, however, the policy failed to include that the resident or the resident's legal representative will receive education regarding the benefits and the potential side effects of the immunization and that this education would be documented in the resident's medical record. Additionally, review of the facility's policy titled "Pneumococcal Vaccinations" revealed that the resident or the resident's legal representative will be offered the vaccination, however, the policy failed to include that resident or the resident's legal representative will receive education regarding the benefits and the potential side effects of the immunization and that this education would be documented in the resident's medical record.

2a. R7 was initially admitted to the facility on 3/15/05. Review of the pneumococcal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 10 immunization informed consent document dated 3/14/05 revealed that R7 was offered the pneumococcal immunization and refused due to the reason that "never had it before and do not want it." Review of the facility's policy titled "Pneumococcal Vaccinations" indicated that a refusal of vaccination should not be used as a basis for future indication of same. Each year, when the influenza vaccine is offered the pneumococcal vaccination should be offered to those who have refused and re-educated offered Record lacked evidence that the pneumococcal vaccination was re-offered since the initial refusal on 3/14/05. Interviews with E4 (Licensed Practical Nurse/Unit Manager) on 5/12/11 at 10:30 AM and with E2 (Director of Nursing) on 5/12/11 at 10:45 AM confirmed that the facility failed to re-offer the vaccination since the initial refusal on 3/14/05. 2b. Review of R7's influenza immunization consent document dated 3/14/05 revealed that R7 refused the immunization due to reason that "last time she got it, she got really sick-do not want to take that chance again." Review of the October 2010 Medication Administration Record revealed that R7 received the influenza immunization on 10/22/10, however, the record lacked evidence of education related to the benefits and the potential side effects of this immunization. Interviews with E4 on 5/12/11 at 10:30 AM and with E2 on 5/12/11 at 10:45 AM confirmed the findings.	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interview it was determined that the facility failed to store food under sanitary conditions. Findings include: 1. On 5/18/11 at 8:45 AM in the Magnolia nourishment room the following items were found opened, unlabeled and undated; honey, partial loaf of sweet bread, strawberries, mixed fruit, ice tea in pitcher, lemonade in pitcher and an open can off orange soda. The unit manager E6 was present during the inspection 2. On 5/18/11 at 9:27 AM in the Scott nourishment room the following items were found opened, unlabeled and undated; 2 liter bottle of Minute Maid lemonade, pitcher of lemonade, and a 2 liter bottle of coke. 3. On 5/18/11 at 10 AM in the Holly nourishment room the following items were found opened, unlabeled and undated; a 16 oz tub of reduced fat cream cheese with lid partially off and a container with slice of lemon meringue pie.	F 371	**F 371** 1. Food/ drinks in the nourishment rooms found to be opened, unlabeled, and undated were discarded. 2. House wide Nourishment rooms were evaluated for opened, unlabeled, and undated items and were discarded as applicable. 3. The Staff Developer or designee will re-in-service the staff on the storage of food under sanitary conditions. The Policy and procedure for proper storage of food will be reviewed and revised as necessary. Weekly audits will be conducted to evaluate whether food is stored properly in the nursing unit refrigerators. 4. The results of the audit will be forwarded to the Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will determine the need for further audits and or action plans.	July 26, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 These findings were reviewed with the facility administration on 5/18/11.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R200 and R194) out of 26 residents in the sample the facility failed to ensure that indication for the use of medication, potential duplicate medication therapy and lack of behavior monitoring for hypnotics were addressed by the consultant pharmacist. Findings include: 1. Cross refer F329 example #1. R200 had a physician's order originating 2/4/11 for Melatonin 3 mg. qd for sleep and an order originating on 4/12/11 for Ambien 10 mg. hs for sleep. High Risk Review notes dated 4/21/11 did not mention the use of Ambien only melatonin.	F 428	**F 428** 1. R200's behavior monitoring for insomnia is being done. Per Physician order, R200's melatonin was discontinued on 6/7/11. R194 diagnosis for aspirin was added to the medical record. The Pharmacist Consultant was made aware of the potential duplicate medication therapy. 2. Residents receiving medications for insomnia are at risk for this deficient practice. Resident's receiving aspirin therapy are at risk for this deficient practice. 3. The Staff Developer or designee will in-service Nursing Staff on behavior monitoring for Resident's receiving hypnotics. The Staff Developer or designee will in-service the Nursing Staff on ensuring the indication for the use of medications. Random Audits will be done on resident's receiving hypnotics to evaluate whether behavior monitoring is being done. Random audits will be done to evaluate whether medications have indication for usage. 4. The results of the audits will be forwarded to the Quality Assurance and Assessment Committee. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.	July 26, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 13 The pharmacy review dated 4/27/11 noted the use of melatonin for sleep but did not indicate the awareness of the Ambien being added to the medication regime. There was also no mention of the lack of behavior monitoring for insomnia. An interview with E2 (Director of Nursing/DON) and E6 (Unit Manager) on 5/16/11 at 1:20 PM revealed that the physician had just been contacted and wanted to continue with both sleep aids. E2 and E6 confirmed that this potential duplicate therapy had not been identified by the facility and that behavior monitoring for insomnia was not being done. 2. Resident R194 was being given aspirin at 8 (sic) mg. daily. No diagnosis or rationale was listed for the use of this medication. The unit manager, E4, was interviewed regarding the use of the aspirin and referred to the RNAC, E9, who indicated the aspirin was on R194's regimen upon admission and was being used prophylactically related to falls. The monthly pharmacy reviews did not address the use of aspirin for this resident.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on review of the medication storage refrigerators on all of the units,and review of pharmacy policy and procedure concerning refrigerated storage of medications, it was determined that the facility failed to properly store medications. Findings include: 1. On 5/16/11 at 11:35, the Scott unit medication refrigerator log for May 2011 indicated temperatures of 28 to 34Fahrenheit (F) for the medication refrigerator. The current internal	F 431	F 431 1. All Residents receiving medications which require refrigeration storage are at risk for this deficient practice. 2. The medication room refrigerators on all units will be adjusted to bring the temps within the range of the pharmacy policy 3. Medication refrigerator temps will be monitored with an updated medication refrigerator log 4. The Staff Developer or designee will re-in-service the Nursing Staff on the proper storage of medications that require refrigeration. Audits will be completed weekly x 4 weeks to evaluate whether medications requiring refrigeration are stored in the appropriate temperature range 5. The results of the audits will be forwarded to the Quality Assurance and Assessment Committee. The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans.	6/22/11 7/26/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 refrigerator thermometer was 30F. Additionally, the surveyor thermometer read 28F at 1:13 PM. 2. On 5/16/11, the Magnolia unit medication refrigerator had an internal temperature of 33F. Magnolia unit medication refrigerator log for May 2011 indicated a 32 to 36F temperature range for the month. 3. On 5/16/11, the Holly unit medication refrigerator internal temperature was 30F. The temperature log for May 2011 ranged between 28 and 32F. The pharmacy policy and procedure for medication storage in the facility, section ID1:Storage of Medications, indicated in bullet point K, the following; "Medications requiring 'refrigeration' or 'temperature between 2C (36F) and 8C (46F)' are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage 'in a cool place' are refrigerated unless otherwise directed on the label."	F 431		

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Capitol Healthcare Services

DATE SURVEY COMPLETED: May 18, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey and complaint visit was conducted at the facility from May 11, 2011 through May 18, 2011. The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and other facility documentation as indicated. The census on the first day was 109. The Stage II sample included 26 residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey	Cross reference Plan of Correction for CMS 2567 F166, F241, F248, F279, F329, F334, F371, F428 and F431 July 26, 2011

Provider's Signature _____ Title Administrator Date 6/8/11

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Capitol Healthcare Services

DATE SURVEY COMPLETED: May 18, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	report date completed 5/18/11, F166, F241, F248, F279, F329, F334, F371, F428, and F431.	